ALCOHOLISM – What every doctor should know

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The general practitioner (or the doctor at the Casualty Department) has assumed the single most important role in our fight against one of the most devastating diseases of our time – alcoholism. It has now been accepted that the most useful role for doctors at present are, first to detect the many heavy drinkers passing through our hands at an early a stage as possible, and then to provide brief interventions designed to persuade them to drink less, and second to do what we can to help change the drinking habits of the population as a whole, a task which may involve changes in our own behaviour (Kendall R.E. (3)).

Alcoholism means so many things to different people – weakness in character to the man in the street, a vice to the moralist, a personality deficit to a psychologist, a social problem to a sociologist and a sin to a clergyman (Glatt, M. (2)). In the end however it becomes a medico-social problem and the province of the doctor. One may add that our attitude changes from one circumstance to the other – a girl who gets drunk at a party elicits our disgust, a father who spends too much on drink our condemnation, a man who drives under the influence our censure, a drunkard who beats his wife our blame, an intoxicated guest who tells dirty jokes our attention but when the excessive drinker becomes an alcoholic we all agree that he requires medical treatment.

Who is an Alcoholic?

Like the proverbial elephant it seems no one can define an alcoholic but everybody recognises one when he sees him. This is the greatest block to diagnosis. The *"faccia di pulcinello"*, the spider naevi, the palmar flush and the bloated belly are rarities confined to the 'skidrow' stereotype. An alcoholic may in fact be working with you, sitting next to you in a stadium, talking to you in a party, a member of your family. Alcoholism is not an "either-or" entity like pregnancy (you either have it or you don't) but it is a matter of "more or less" like heart disease which starts insidiously but progresses relentlessly. A young doctor must keep in mind the presence of alcoholism in many varieties of patients – an alcoholic may present at the Casualty Department demanding something for his nerves or his stomach, a certificate for sick leave, a minor accident – or the greatest surprise of all - the alcoholic may be a woman.

The greatest lesson of all : don't rely on how the patient looks, nor listen to what the patient says but enquire what the patient does!

What Alcoholics Do

An alcoholic drinks excessively but it is not the excess that forms the hallmark of the disease (the alcoholic starts getting drunk on less and less drinks as tolerance wanes) but the pattern. He drinks not just for pleasure but because he must. He drinks every day, every morning and perhaps alone to avoid withdrawal (sweating and shaking). He is obsessed with drink so that he sneaks drinks and adopts strategies to get more drink and in the end he feels guilty about it. At this stage (prodromal stage), intervention by the family doctor would save the patient from eventual destruction.

The start of the "road of no return" begins with the patient getting "black outs" (forgetting complicated tasks he did the night before, surprised when told about them but recalls them on further drink). The alcoholic has characteristically lost his control on drinking so that "the person with alcoholism cannot consistently predict on any drinking occasion the duration of the episode or the quantity that will be consumed" (W.H.O.). He loses interest in his family, absents himself from his job and becomes a menace on the road. He feels guilty about the condition he finds himself in but he drinks further to drown his sorrows.

The chronic stage is reached when there are physical and mental complications. He loses his job, beats his wife, becomes impotent and blames his partner and soon he is in delirium tremens if he stops drinking (e.g. admitted to hospital for a medical or surgical condition) or dementing

in various ways (Wernicke-Korsakov).

His liver shows various stages of the cirrhotic process and his heart, pancreas and nervous system produce the classical clinical picture of alcoholism.

Catching the Alcoholic in Time

The doctor in his clinic or at the Casualty Department (the trenchline of our profession) should remember "the forgotten illness" and must know how to ask relevant questions.

GUIDELINES FOR SELECTION

(a) *"HIGH RISK GROUPS"*

Certain walks of life (*occupational hazards*):
- catering trades,
- travelling salesmen,
- entertainers,
- seamen,
- hard pressed executives,
- businessmen.

(b) *PHYSICAL CLUES*

Gastro-Intestinal: Vomiting, nausea, dysphagia, vague abdominal pains, diarrhoea.

Neurological: headache, in-somnia, 'black out'.

Cardiovascular System: palpitations.

Traumatic: frequent accidents, falls or injuries, cigarette burns.

(c) *PSYCHOLOGICAL CLUES*

Behavioural: frequent financial difficulties, excessive absenteeism from work, poor performance, marital difficulties, immoderate use of coffee, tobacco, tea.

Emotional: Anxiety, panic attacks, hallucinations, depression, suicidal attempts

TABLE 1

He must be aware of the "high risk group" and how they present themselves. (Table One). Doctors easily associate dementias and liver disease with alcoholism but its relationship with pancreatitis, hypertension, cancer, heart disease, infertility, infections, accidental and self inflicted injury and the foetal-alcohol syndrome are less well known.

Alcoholism is a disease and behaves like any other physical disease with its own aetiology, signs and symptoms, prognosis and treatment and must therefore get the medical response it deserves.

Alcoholism has a genetic component (risk factor) and the family of the alcoholic (especially the children) should not escape the terms of reference of the caring physician.

Alcoholism is not the monopoly of the lower social strata (the milk of the poor) but the signpost of affluence because as wages rise higher and higher, alcohol becomes relatively cheaper and with more and more availability the problem drinkers multiply. Alcoholism is not only a medical disease but it is also a social disease and as social problems create a craving for alcohol, alcohol in turn compounds social problems so that alcoholism must not be tackled on the medical model alone but rather on the medico-social model. The alcoholic must be saved from himself and the company he keeps but must also be helped in his confrontation with the employer, the creditors and sometimes the police. No challenge greater than this has ever faced a doctor devoted to the physical, psychological and social well being of his patient.

The practitioner should know how to ask questions relating to alcohol and for this purpose many questionnaires exist which are all highly suitable. I would recommend the CAGE questionnaire. (Table Two).

The *CAGE* Questionnaire

(1) Have you ever tried to **C**ut down on drinking?
Was it difficult?
How was it done?
Why did you start drinking again?

(2) Have you ever been **A**nnoyed about criticism?
Who criticised you?
Why was your drinking criticised?
Was the criticism justified?

(3) Have you ever felt **G**uilty about your drinking?
What caused the guilt?
Does your behaviour change when you are drinking?
Have your ever resolved not to drink as a consequence of your behaviour?

(4) Have you ever had a morning **E**ye-opener?
Do you drink in the morning in order to make it through the day?

Since 18: any fracture or dislocation? injuries in road accidents? injuries from fights? head injuries?

TABLE 2

Management of the Patient

Once the suspicion and the confirmation of "excessive drinking" have been sustained, the doctor should assess whether this is simply "excessive" drinking becoming too frequent or the patient is already an "alcoholic". It must be remembered that excessive drinking at any time is a dangerous proposition in this age of the motor car. If the patient is in the first category then the doctor must determine whether there are any precipitating factors like psychological or social difficulties (which must be tackled) or whether the "habit is turning into a vice". The simple advice is a warning and simple directives: The patient must stick to a routine of no more than 21 units a

week (1 unit = 1 whisky, 1 beer, 1 glass of wine or equivalent) with two alcohol free days a week in between. For women the allowance is 14 units. If the patient is a "prodromal" alcoholic (i.e. there are no signs of damage to the liver or the central nervous system which must be looked after by a physician) then one proceeds on different lines.

First he must be challenged to assure him that he has lost control over his drinking (in spite of his resolutions) and that he cannot give up his drinking alone. You challenge him that for the next three to four weeks he must continue to attend the bars, meet the same friends and keep the same hours as he is doing at the moment. Nothing is to change but he must restrict his drinking to not more than three drinks each time. An alcoholic will not stand it, he may give up drinking altogether for weeks (on the wagon) but relapse is inevitable.

The next time around, shameful in defeat or grinning with Dutch courage you react by assuring him that you accept him and will do your best for him. Do not give him any Valium or refer him to a psychiatrist or to the Alcoholics Anonymous (A.A.). These agencies are no better than you are and in so doing you lose the patient.

You explain and emphasise all the possible consequences of heavy drinking – not only dementia and cirrhosis but also impotence and injuries. This is part of the educational process so that the patient may in fact start assuming responsibility for his actions. As a sign of good faith he must start getting off alcohol ALTOGETHER – this is simpler than cutting down – and to report immediately any withdrawal symptoms; like confusional state or hallucinations. He must also avoid attending bars, eating out or going to parties. His wife may not like such seclusion from social life but probably she has already been cut off for a long time; either because he prefers other venues where he can do anything without censure or because she has refused to be made a laughing stock or a fool in public (or scared of driving with him). Furthermore she must be implicated in treatment - praising him when he does not "fall", supporting him when he does.

Then he must be put on the road to recovery which entails four milestones - the first is that he must have a constant reminder that he must not drink. A nagging wife or a peptic ulcer are not prerequisites but the patient must tell everybody around that he is dry and say "no thank you, I don't drink". The second milestone is to tolerate a "vice-vice substitution" which means he is allowed to drink frequent coffees or teas or simply water (better than cigarettes or fatty foods). The third milestone is the enhancement of self esteem by being encouraged and praised (and accepted by the wife!) and the final and most difficult is the improvement of social fabric which means new friends, new activities and new commitments. The wife must be warned that she must now share decisions and tolerate him around.

An alcoholic who is dry should never be allowed to revert to a "social drinker" but only to a total ban on alcohol. The chances of success are not high but in any case worth the time the doctor can afford. What he is actually doing is investing in a change of life style for his patient which is much more than is expected from him.

LEVELS OF PREVENTION

PRIMARY PREVENTION

(a) Policies regulating terms of commercial availability:
Taxation, Licensing hours,
Age limit on alcohol sales,
Limits of alcohol sold, reduction in outlets (bars, restaurants)

(b) Policies that seek to influence drinking practices:
Law and education

(c) Policies designed to render the external environment less hostile:
sale structure, safe machinery, traffic control, road signs, emergency services

SECONDARY PREVENTION

The medical and paramedical staff should be aware of the problems of alcoholism and be equipped for early detection.

TERTIARY PREVENTION

Hospitals, Outpatient Departments, Rehabilitation Units
Day Units, Alcoholics Anonymous

TABLE 3

On the same lines the medical doctor should support any measures or policies listed in Table Three in the Primary prevention of alcoholism and should be in the forefront in Secondary prevention. The doctor is being invited not only to "cure diseases" (which he rarely does) but to participate in changing life styles for his co-citizens. In the case of alcoholism, brief counselling sessions by General Practitioners often succeed in preventing "heavy drinkers" drifting into "problem drinkers" which is highly satisfying and cost effective.

There is no statistical evidence of any significant difference between inpatient or outpatient care and simple advice (Valliant G. (5))

References

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